Compliance Evaluation

Dorothea Dix Hospital

Date of Site Visit: September 26-27, 2007

Date of Report: October 16, 2007

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Code for reading this Evaluation

C = Compliance. Hospital has substantially complied with the requirement.

SC = Significant compliance. Considerable compliance has been achieved on the key components of the requirement, but refinements remain to be completed.

PC = Partial compliance. Hospital has made reasonable gains toward being in compliance with the requirement, but substantial work remains.

NC = Not in compliance. Hospital has made inadequate progress towards being in compliance.

All four measures reflect current outcomes of Hospital's work and are neither a measure of intent nor of effort. In fact, minimal effort in one area might achieve compliance on one item while significant effort in another may still leave the Hospital rated not in compliance on that item.

Font in this Evaluation.

Italics. Items in italics represent those found to be in compliance at the time of prior evaluation.

Bold Face. Items in bold face reflect findings from this evaluation.

DATA BASE

Documents

Statistics
- Admissions and Average Daily Census by Fiscal Year, 2000-2008
- Number of Patient to Patient Assaults Per Year, 2000-2007
- Number of Patient to Staff Assaults Per Year, 2000-2007
- Number of Serious Patient Injuries Per Year, 2000-2007
- Restraint Episodes and Hours, 2000-2007 (July)
- Seclusion Episodes and Hours, 2000-2007 (July)
- Number of days Admissions have been closed due to the 110% rule from initiation through August 31, 2007
- Nursing Service 24 Hour Report 9-24-07

Dual Diagnoses: MI/MR
- List of all patients with Axis II diagnosis of MR or Borderline IQ
- MR/DD packet for last five MR admissions
  - 1063718
  - 1079186
  - 0130323
  - 0383090
  - 1081578
- Treatment Plans for three Civil Patients with MR Diagnoses
  - 1065991
  - 0126342
  - 1012052
- Treatment Plans for three Forensic Patients with MR Diagnoses
  - 0393898
  - 1071209
  - 0997021

Dual Diagnoses: MI/SA
- SA Assessment Tools
  - Psychiatric Assessment, page 4
  - Biopsychosocial Assessment, page 3
- Treatment Plans for five Patients with Substance Abuse
  - 0091263
  - 1076172
  - 1077908
  - 1043896
  - 1056218

External Reports
- JCAHO 8-14 to 8-15-07
- JCAHO Survey Follow-up and Actions 2007

Medical
- Patient deaths, 1990-2007 (YTD)

Patient deaths with DOA, DOD, DODeath, Cause of death, 1-1 to 9-14-07
List of patients with hearing impairments (excluding gero)
List of patient deaths, 2007
Death reviews, 2007

Staffing

Percent RN shifts by agency and per diem nurses, August 2007
Number of FTE psychiatrists providing direct care (excluding N/W coverage) and number of FTE vacancies
List by classification of number of separations and number of new hires/reinstatements/promotions, 3-1 through 9-30-07

Psychotropic Medication

Five Admission Assessments with rationale for Medications Prescribed at Admission
0991263
1014092
1037414
1082177
1082761
List of all patients with orders for antipsychotic medications by patient with medications, dosage, how administered
Psychiatry progress notes for five patients on LT unit, 1-1-07 through 8-31-07
0374357
1003136
1076905
0986000
1077062
Psychiatry progress notes for five patients on Forensic Unit, 1-1-07 through 8-31-07
1044078
0396604
0155088
1005818
1042043
Psychiatry Progress Notes for five Patients on the Gero Unit, 1-1-07 through 8-31-07
0336389
1030270
1074977
1081143
1069301
Policy on PRN psychiatric medication: Automatic Stop Order (ASO) for all Medication Orders, 1-1-07
List of all Patients on Benzodiazepines by Patient including Dosage, how Administered, Reason for Medication
List of STAT orders 8-1 through 8-14-07: NONE
Medication Chart Reviews for Polypharmacy

0971799	4-25-59	9-12-07	
0391835	8-22-71	5-8-05	
1064660	3-10-62	9-13-07	9-14-07

0376140	9-4-58	8-24-07	9-19-07
0392607	10-3-67	11-20-95	
0398376	1-7-70	7-16-07	
1035338	12-17-82	9-14-07	
0922303	5-14-50	9-6-07	
0981820	10-1-48	3-18-07	
1077062	12-5-71	1-17-07	
1068424	9-13-47	4-25-07	
0997896	2-1-72	9-23-07	

Table: Ten Most Recent Patients Receiving IM Antipsychotic Medication

Medication Chart Reviews for Most Recent IM Antipsychotic

0362906	10-18-37	9-21-07
0384141	7-26-65	9-25-07
0922303	5-14-50	9-6-07
1084149	3-9-73	9-25-07
0922786	9-16-75	7-27-06

Assessments

Ten Psychiatric Assessments, patients admitted 8-07

1081704
1082857
1082885
1004842
0982621
0391659
1083233
1049538
1041093
1083561

Psychiatric Intake Evaluation

1049538
1041093
1082885
1083233
0391659
1083561

Annual Psychiatric Assessment

1044266	5-4-81	9-25-06

Treatment Plan

Reviews

1081799	8-29-07
0991263	9-10, 9-5, 8-27, 8-22-07
1080715	7-25, 7-18-07
0983961	undated
1082386	8-28, 8-21, 8-15, 8-7, 7-31, 7-24-07
1066287	8-25, 8-1-07
1014092	8-28-07

1079898	9-10-07
0387696	8-13-07
1080995	9-12, 9-4, 8-14, 8-9-07
0955738	8-21, 7-24-07
1077369	8-31, 6-8, 5-1-07
1001372	4-20, 2-12-07; 11-15-06
1082127	9-13, 9-6, 8-30, 8-23, 8-16, 8-9, 8-2-07
1080025	8-22, 6-26, 6-19, 6-5, 5-29-07
0162120	8-29, 5-9-07
1080295	9-12, 8-8-07
0370776	9-17, 9-12-07
30813075 (act)	9-25, 9-21, 7-17
0392743	9-20 and 9-12-07 as one review
1075086	none
1079186	9-17, 9-24
1044266	8-18, 4-11, 1-12-07; 12-27, 11-29-06

Physical Plant

DDH Inspection Reports, January-August 2007

DDH Fire Drill Reports, January-August 2007

DDH Environmental Rounds, March 2 & 5, June 19, 20 & 26, 2007

Central Regional Hospital

Plan for Closure of JUH and DDH, 5-07

Plan for RN Staffing

Educational Needs of Children and Adolescents at CRH

Patient Transition to CRH

Training

List of Staff Training in 2007

Admission

Homeless Admissions, 1/07-8/07

Staff to Staff Communication

Policy on Decreasing Level of Observation: Levels of Observation, 9-1-07

Policy on PSR Notes, i.e., Group Notes: Patient Management Standards at 7, 4-1-06

Behavioral Treatment

Last five behavioral treatment plans completed. Reviewed with CTP.

0997021	6-6-07
1077167	7-9-07
0999146	9-12-07
1065991	8-24-07
1071209	8-17-07

Incidents

Occurrence Report and Unit Event Review: Serious Incidents

Patient	Occurrence	Review
DW	9-18-07	9-24-07
TT	8-21-07	9-5-07
JT	4-27-07	5-31-07
SC	3-6-07	3-22-07

TK	3-5-07	3-5-07
JB	1-22-07	1-26-07

Occurrence Report: Incidents of Concern

Patient	Occurrence	Injury
AM	9-20-07	Serious
JJ	8-8-07	Serious
RN	3-16-07	None
LE	8-16-07	None
TH	9-10-07	Serious
WD	7-22-07	Unspecified
KE*	7-30-07	Moderate
SS*	7-30-07	Moderate
RW*	7-30-07	Moderate
RW*	8-21-07	None
HW	9-23-07	Unspecified

*Fire Ants

PSR

PSR Group Interventions Quick Reference Tool for Treatment Teams, 9-07

Discharge

List of current DDH inpatients with 10 or more DDH admissions

Problem Lists (and supporting documents) for current DDH inpatients with 10 or more admissions

Discharge Summary

0375252	5-14-63	3-7-07	6-12-07

Special Observation

List by ward of patients on Suicide Precautions

Constant Observation
Close Observation
1:1 Staffing

1084117	8-20-93	9-25-07
1084129	12-10-67	9-25-07
0997896	2-1-72	9-23-07

Policy and Procedures

Patient Management Standards: Adult, Child and Adolescent, Forensic Treatment, and Geriatric Psychiatric Services, 2-1-07

Other Medical Records

1084122	6-12-45	9-25-07	
0377389	7-7-54	9-21-07	
1003050	10-22-72	7-27-07	7-31-07
		7-17-07	7-19-07
		1-7-07	7-12-07

Site Visit

Treatment Team Meeting

Female Admit – Stephen Ford, M.D.

0983742 Initial CTP
0392815 TPR
1079308 TPR

Adolescents – James Mayo, M.D.
1070532 TPR
1073431 TPR

Gero – James Mayo, M.D.
1069301 TPR

Female LT – M.J. Keyser, M.D.
0390785 TPR

Forensic – Alyson Kurski, D.O.
0382252 TPR
1059874 TPR

Male Admit – Bruce Warf, M.D.
1083273 TPR
0989512 TPR

PSR

PSR sites visited
- Dogwood
- Brindle
- G-West
- Learning Court 2NC

PSR Groups observed
- Work Therapy
- Hot Topics
- Medication Strategies for Recovery
- Intermediate Computer
- Alternate Programming-Relaxation
- Work Crew Group
- Group Living Skills
- Exercise and Wellness
- Self Directed Search
- Relaxation/Mood Room
- Music and Memories
- Learning Court/Quality Council
- Community Life Skills
- Horticulture
- Computer Lab
- Living Life to the Fullest
- Understanding Your Illness
- Focus Group
- Discharge Planning
- Resources for Community Living
- Take Action: Coping Through Life

Physical Plant

Sites inspected

2E Adult Crisis
2N Male Admission
2S Long-term Male
Cherry Adolescent
3S Forensic Medium

Comprehensive Treatment Plans

Med #	DOB	DOA
1005818	2-1-66	6-7-07
0395398	4-20-69	7-22-93
1043894	7-12-83	8-24-07
0041252	3-7-59	9-1-99
1065991	2-3-92	8-21-07
1083049	2-28-92	8-15-07
1082506	7-20-92	7-24-07
0399181	11-2-19	6-27-07
1042043	6-2-78	8-9-05
1014092	4-22-67	8-15-07
0991123	9-28-57	7-22-07
1077908	5-16-78	8-21-07
0989512	3-27-76	8-18-07
1004892	7-31-57	7-7-07
1082697	8-11-28	8-9-07
1083439	8-24-93	8-30-07
0875630	9-13-59	8-23-07
0955738	10-4-59	7-3-07
1079898	3-2-93	8-9-07
1014092	4-22-67	8-15-07
1081799	10-24-57	8-8-07
1083692	8-14-85	9-10-07
1083760	12-23-85	9-12-07
1064149	3-9-73	9-25-07
0390785	10-28-58	5-20-07
1077011	4-12-91	1-15-07
0989512	3-27-76	8-18-07
1044266	5-4-81	12-29-06
1077746	1-27-93	2-19-07
1080331	2-17-77	5-8-07

Exit Plans: US and NC: Dorothea Dix Hospital

Assessments

Item	Compliance	Findings	Comments and Recommendations
Appropriateness of the admission Other less restrictive settings (VIIB)	*C*	*In a memorandum to Community Hospital CEOs and LME Directors, Mike Moseley, Director of DMHDDSAS stated, "North Carolina's State psychiatric hospitals have been experiencing an upward trend of increased admissions over the past four years. To date, our hospitals have continued to accept patients beyond their capacity in order to accommodate the needs of consumers and local communities. At times, the census on our admission units has been so high that it has caused us serious concerns regarding patient safety and treatment capability. In order to address these concerns, in the future when the census in a hospital's admission unit exceeds 110% of the unit's capacity, we will be delaying admissions from community hospitals until we can decrease capacity to a level that does not jeopardize patient safety and well being." This, in essence, puts a fixed cap on each NC state hospital census, including Dorothea Dix Hospital.* *Per P1: As part of the psychiatric assessment, the admitting physician will attempt to assess the patient's potential risk of dangerous patient behavior(s) and identify, what upsets the patient and less restrictive interventions that help to prevent or diffuse the situation.* *Per P8: Admission of a patient into DDH shall be based on an assessment process which determines that: a) the individual requires treatment which is appropriate to the patient's severity of illness and the intensity of service provided by the hospital or program; b) the treatment required can be appropriately provided; or c) alternatives for less intensive and restrictive treatment, although indicated, are not available.*	*This is an important step towards both maximizing patient and staff safety and allowing staff to effectively engage patients in treatment and rehabilitation. However, with current vacancies, Dorothea Dix Hospital is able to meet the needs of its census at current capacity. Pushing that to 110% may cross a threshold of safety and effectiveness, or may not. The DMHDDSAS and the hospital must evaluate its functional capacity in the 100% to 110% range and adjust its set point to delay admissions accordingly.*

Reviewed all assessments on first five admissions in 2007. Contributions to assessment process by psychiatry (psychiatric intake evaluation, psychiatric assessment, first Attending note), medicine (H&PE, medical treatment plan), nursing (nursing assessment) and social work (biopsychosocial assessment) were present. MISA is ascertained on each one of those assessments. DDH has a plethora of patients admitted with substances contributing significantly to the presentation (4/5 of these cases), so the duplication may prove helpful in determining validity and reliability of reported substance use history. The Attending physician signs off on the assessments done by medicine and by other psychiatrists in the admitting process.

Admissions of persons terminally ill and near end of life burden DDH and may well be outside the scope of DDH's capacity (or mandate?). See for example, #1073736.

Admissions and Average Daily Census by Fiscal Year:

FY	Average Census	Admissions
2000*	411	2450
2001	393	4451
2002	344	3879
2003	304	3869
2004	292	4017
2005	310	4371
2006	308	4532
2007	304	4894
2008**	300	923
2008 annualized	X	4265

* includes Data for 10/1/99-6/30/00
** includes Data for 7/1/07-9/17/07

<table>
<tr>
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<td>Homeless Admissions (2007):

<table>
<tr><th></th><th>% of Total Admission</th><th>% of Hmless Individuals with Prior Admissions</th><th>Readmitted 30 days # and %</th></tr>
<tr><td>Jan</td><td>13.5</td><td>82.2</td><td>2 (4.4)</td></tr>
<tr><td>Feb</td><td>12.0</td><td>77.1</td><td>6 (17.1)</td></tr>
<tr><td>Mar</td><td>11.3</td><td>86.7</td><td>6 (13.3)</td></tr>
<tr><td>Apr</td><td>11.3</td><td>73.7</td><td>1 (2.6)</td></tr>
<tr><td>May</td><td>7.9</td><td>89.3</td><td>1 (3.6)</td></tr>
<tr><td>Jun</td><td>8.3</td><td>70.8</td><td>2 (8.3)</td></tr>
<tr><td>Jul</td><td>13.4</td><td>76.2</td><td>7 (16.7)</td></tr>
<tr><td>Aug</td><td>11.8</td><td>79.4</td><td>4 (11.8)</td></tr>
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<tr>
<td>Multidisciplinary with attention to co-morbid diagnoses, i.e., MRMI and MISA (IIIA1,B1,B5)</td>
<td>PC</td>
<td>The census on the day of the visit showed 58 patients with MI/SA and 37 patients with MI/MR.

Psychiatric
Based on a review of 10 Assessments (see Database):
Well done historical review
Mental status exam appropriate to presentation
Formulation is absent or a Cliff Note version of data, i.e., not a formulation
Initial Plans run from on point and well done to generic and useless
SA data present, but not always properly diagnosed
Diagnoses are consistent with data (excluding SA diagnoses)
Diagnoses completed on Axis I-IV

Patients with Axis II Diagnosis of MR or Borderline IQ (9-14-07)
<u>Unit</u> <u>No. of Patients</u>
Forensic 22
ALM 4
GERO 3</td>
<td>Policies and Procedures
Nursing Assessment Policy: Policy should be modified to require nursing assessment to be completed by 8 hours. Twenty-four hours is too long and potentially dangerous/unsafe.</td>
</tr>
</table>

		AAM 4 **AAF 5** **WMS 3** **Total 41** **Recidivism** **28353 discharged 8-10-07, admitted 8-27-07. Psychiatric Assessment mentions, but does not initiate addressing this.** **Diagnosis** **When diagnoses cannot be clarified at the time of admission, there needs to be efforts, as part of the CTP, to reach a definitive diagnosis. Evidence that this is not happening is easily found.** **Med# Diag LOS Comment** **1077167 I Psychotic 2.5 mos No change in** **D/O NOS admitting diag.** **R/O Schizoaff No evidence on** **D/O CTP of any** **R/O Pedophilia interventions to** **R/O ADHD change diag.** **II R/O Pers D/O NOS** **0997021 I Impulse Contr 1.5 mos No change in** **D/O admitting diag.** **R/O ADHD No evidence on** **II R/O Mild MR vs BIF CTP of any** **Antisocial traits interventions to change diag.** **1071209 I ADHD NOS 3 wks No change in** **II R/O Mild MR admitting diag.** **No evidence on CTP of any interventions to change diag.** **1065991 I Mood D/O 3.5 wks No change in admitting diag. No evidence on CTP of any interventions to**	

		change diag. **Other cases with similar findings:** **0399181; 1065991; 0395398; 1001372; 1080715; 1064149** **And particularly noteworthy, a 13-year-old (0991263) with diagnoses of:** **Mood Disorder NOS** **Conduct Disorder; childhood onset** **Marijuana Abuse** **Hx of PTSD** **R/O Bipolar Affective Disorder** **ADHD combined** **Psychosis NOS** **There are occasional cases where diagnoses are refined: 0390785 from Personality D/O NOS to Borderline Personality D/O** **Care and treatment of individuals with MR needs to be particularly well conceived and executed as it appears DDH is the destination for persons with MR who can only be described as products of disastrous community situations. Some have no clear DSM-IV diagnosis other than MR. See for example: 0375252 (discharged to O'Berry Center after 3-month stay).**	
Psychological identifying Suicide risk (IIIB2)	*C*	*Suicide risk, a frequent reason for admission was appropriately recognized at the time of admission and addressed. Suicidality and the risk for self-injurious behavior are queried by psychiatry, medicine, nursing and social work. Medicine picks up past evidence of self-abuse on the physical exam; nursing picks it up on the physical assessment.*	
Self-injurious behavior risks (IIIB2)	*C*	*See suicide risk above.*	
Cognitive strengths and	*C*	*Mental status examination was formally conducted on*	

weaknesses (IIIB2)		*the psychiatric intake evaluation and on the psychiatric assessment. Abnormalities on the mental status examinations were noted in the first Attending note. The nurse, in her/his assessment, includes cognitive functioning, as does the social worker.*	
Identify and prioritize patient needs with particular attention to "special needs" Suicide risk (IIIB4) Self-injurious behaviors MI/MR MI/SA (IIIB2) Hearing impaired (IIIB6)	 *C* *C* C	 *In assessments by admitting MD, attending MD, nurse, social worker.* *Same as above.* DDH able to identify hearing impaired patients. They represent about 1% of census (3 patients) excluding Gero Unit. *Deaf unit at BH.*	
Psychopharmacological examination of appropriateness of current and ongoing pharmacological treatment for behaviors (IIID6)	PC	**Medications** **I reviewed five Admission Assessments provided in response to a document request for Admission Assessments with rationales for medications prescribed at admission:** **0991263** **1014092** **1037414** **1082177** **1082761** **These show improvement, but remain wanting. The medication rationale often** • **fails to be provided by the admitting physician**	

<table>
<tr><td></td><td></td><td>is provided by the attending psychiatrist, but often fails to be specific
better characterizes side effects than specific effects, i.e., what specific symptoms are being treated
is silent on risk/benefit of using a benzodiazepine in a person with significant SA history and/or current use</td><td></td></tr>
<tr><td>Medical (VB)</td><td>C</td><td>Assessments well done.

Patient Deaths
<table><tr><th>Year</th><th># of Patient Deaths</th><th>Death Post-Discharge</th></tr><tr><td>1990</td><td>10</td><td></td></tr><tr><td>1991</td><td>61</td><td></td></tr><tr><td>1992</td><td>41</td><td></td></tr><tr><td>1993</td><td>43</td><td></td></tr><tr><td>1994</td><td>37</td><td></td></tr><tr><td>1995</td><td>57</td><td></td></tr><tr><td>1996</td><td>50</td><td></td></tr><tr><td>1997</td><td>56</td><td></td></tr><tr><td>1998</td><td>54</td><td></td></tr><tr><td>1999</td><td>44</td><td></td></tr><tr><td>2000</td><td>40</td><td></td></tr><tr><td>2001</td><td>17</td><td></td></tr><tr><td>2002</td><td>13</td><td>1</td></tr><tr><td>2003</td><td>10</td><td>1</td></tr><tr><td>2004</td><td>7</td><td>1</td></tr><tr><td>2005</td><td>7</td><td>1</td></tr><tr><td>2006</td><td>9</td><td>2</td></tr><tr><td>2007 (YTD)</td><td>4</td><td>1</td></tr></table>
From 1990 through 2001, many of the deaths at Dix were from patients on a med-surg visit from another state facility.</td><td></td></tr>
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Treatment Plans

Item	Compliance	Findings	Comments and Recommendations
Individualized (IIIA5)	**PC**	**Treatment Planning** **JCAHO survey (8-07) noted inadequacies in Nursing Care Plans.** **Initial Plan of Care is limited to psychopharmacologic interventions (completed by psychiatrist).** **Significant improvement. Much less use of boilerplate language. Each component more individualized. Much decreased use of job descriptions as interventions.** **Exceptions are Initial Treatment Plan and goal statements of Acute Unit.** **For example, 28353: largely filled with nonindividual generic statements:** **engage in treatment milieu** **support efforts to change** **engage in alcohol psychoeducation and AA** **engage in treatment effectively and therapeutically** **continue preadmission meds**	**Findings based on review of 17 CTP's, one per Treatment Team – see Database.** **Annotated copies of the CTP's are returned with this report – see Attachment 1.** **Also a review of all attendance rosters for PSR groups, afternoon, 9-25-07.**
Interdisciplinary (IIIA5a)	**PC**	**DDH uses different forms on different units for the CTP. Some forms have no signature page and hence it is not possible to ascertain who attended and participated. Interventions are sometimes interdisciplinary (an improvement), but often not. No one other than SW is ever involved in discharge planning.**	**Standardize CTP form with modification only as necessary for unique functions of a unit.** **Focus on development of cross discipline and multidiscipline interventions.**
Based on Assessment data (IIIA5a)	**PC**	**CTP reflects reason for admission, diagnoses, strengths, reasons for continued stay. Problem: rule out diagnoses, NOS diagnoses, diagnosis X vs. diagnosis Y show no evidence in CTP of being addressed. The number of such instances is significant. See pages 11-12.**	

Attend to co-morbid diagnoses (IIIA1, B5)	**PC**	**Yes for MI/MR** **MI/MR** **Five MR/DD Admission Packets reviewed:** **1063718** **1079186** **0130323** **0383090** **1081578** **These are very well done and provide the basis for the IDT to proceed with treatment planning and treatment/rehabilitation cognizant of any special needs the patient has.** **The MR/DD Admission Packets are facilitating the IDT to write well constructed CTP's for this population. I reviewed six plans for MI/MR individuals:** **Civil Patients** **1065991** **0126342** **1012052** **Forensic** **0393898** **1071209** **0997021** **These CTP's showed marked improvement and many are quite good.** **When the MR diagnosis is a rule out (R/O) or in a differential diagnosis, they need to be interventions aimed at finalizing the diagnosis.** **No for MI/SA.** **SA diagnoses present, but not listed as a problem and no interventions. SA is a problem with interventions,**	

		but not a diagnosis. See annotated CTP's. SA interventions uniformly inadequate. **Dual Dx: MI/SA** **I reviewed five CTP's for patients dually diagnosed with MI and SA:** **0091263** **1076172** **1077908** **1043896** **1056218** **Only 2/5 had the diagnosed SA as a problem. The other three had no interventions for SA. The two with the SA problem had inadequate interventions for this problem. SA groups were few in number and met an inadequate number of times/week.** **DDH needs a substance abuse program/track/sufficient offerings within its PSR Mall for persons dually diagnosed with MI and SA.** **"Polysubstance dependence" is not a DSMIV diagnosis.** **SA not attended to** **For example:** **0387696 Polysubstance** **0875630 Cocaine** **1004892 Cocaine, others?** **0991123 "illegal substances"** **1083049 Marijuana, alcohol** **1080295 Alcohol** **1077011 Alcohol, marijuana, tobacco** **1044266 Alcohol, cannabis, cocaine, Tobacco** **SA has Inadequate Plan** **1080351 Cocaine, opiods, marijuana, Benzodiazepines**	

		5-18-07 Brought cigarettes and wine to ward from courtyard, never addressed clinically by anyone. Restrictive to ward x 72 hours by MOD. Not examined.	
Involve family/guardian when appropriate (IIIA3)	**SC**	**Often cannot tell – see remarks under "Interdisciplinary." Sometimes clearly indicated in other ways, but often not. No evidence of guardian review of plan if guardian could not attend. Observations of Treatment Team Meeting showed good family and/or guardian participation. Effort to include family by phone if could not be present. Guardian sometimes absent.**	
Involve patient in identifying goals and objectives (IIIA3)	**PC**	**Often cannot tell – see remarks under "Interdisciplinary." Sometimes very clear with patient quotes; often not clear; often in language not comprehensible to patient. Observations indicate an effort, but generally a misguided one to involve patient. Too often it's a faux offer resulting in faux participation.** **Rx Plans** **What drives treatment during the early days of hospitalization? Absent ITP, e.g., 1084122 (gero service).**	
Reviewed and revised as clinically indicated (IIIA5b)	**NC**	**Treatment Plan Reviews (TPR) as observed are marginally useful at best. Teams do not organize the meeting by problems – often problems are never mentioned. Presentations are made by each staff of all he/she is doing.** **TPR's as written documents are just about uniformly useless. Document not organized by problem. Virtually never reviewed a TPR that resulted in a changed document on the CTP.** **DDH is not meeting its own requirements:** **Each patient's treatment plan shall be evaluated**	**Change the TPR forms.** **Teach IDT's how to conduct TPR's or teach the Treatment Plan Coordinators, at least.**

		periodically at multidisciplinary treatment team meetings. The treatment team shall review and document the patient's progress towards each goal in the treatment plan and shall revise the plan as needed based on the patient's clinical condition, but no less often than weekly for the first month, monthly for the next two (2) months, and then every two months. Treatment plans may be revised to reflect active care, ongoing discharge planning, and participation by all appropriate disciplines. **In Forensic Programs, treatment plans are to be reviewed every 3 months.** **The plan shall be rewritten when:** **a) there are significant changes in the patient's condition/problems, which warrant reconstruction of the plan** **b) the plan is not workable in its present form** **c) in all cases the plan is to be rewritten annually within the thirty (30) day period following the anniversary of the date of admission** **Seclusion/Restraint Usage** **1075086 no meeting of team despite 3 episodes of S/R in 24 hours after 9 days in DDH. Need to meet even if CTP not due.** **1079186 no TPR in response to meeting threshold, but there is a Restrictive Intervention Prevention Plan done 9-26-07, but this does not involve IDT.**	
Treatment Plan Content includes Suicide precautions (if appropriate) (IIIB2)	**SC**	**Suicidality is generally addressed in CTP's in problem, STG's, interventions and others:** **1083692 problem, STG, intervention** **1083760 problem only** **1084149 problem, STG, intervention** **0390785 problem, STG, intervention – on acute managing high risk situations – on LT**	

Measurable behavioral goals and objectives, i.e., basis for quantifying progress (IIIA5a)

PC

Often not even an attempt. Often an attempt, but not correctly constructed. For example, 0390785: patient will "feel…", "report…", "seek…", "attend" (when not a problem). Sometimes appropriately done.

Emphasis on teaching alternative adaptive behaviors (IIIA6)

NC

A substantial percentage of interventions are not interventions at all, but rather descriptions of interventions or statements of intent. There is a paucity of skill development in the CTP's. Groups are not specifically assigned as interventions to focus on skill development for a specific STG. When alternative adaptive behaviors are the focus of 1:1 interventions, the frequency and time allotment could never effectuate an outcome, e.g., "10 minutes weekly."

Behavioral Treatment Plans

Med #	Date of Plan	Diagnoses	Comments
0997021	6-6-07	I. Impulse Control D/O R/O Schizoaff D/O R/O Pedophilia R/O ADHD II. R/O Pers D/O NOS	Plan is a behavioral management plan, not a behavioral treatment plan. Plan uses levels to try to affect behavior, but levels should be assigned based on level of risk.
107767	7-9-07	I. Impulse Control D/O R/O ADHD	Plan is a behavioral management plan, not a

		II. Mild MR vs BIF Antisocial traits	behavioral treatment plan. Plan uses levels to try to affect behavior, but levels should be assigned based on level of risk.
1071209	8-17-07	I. ADHD NOS II. R/O Mild MR	Plan is a behavioral management plan, not a behavioral treatment plan. Plan uses levels to try to affect behavior, but levels should be assigned based on level of risk.
1065991	8-24-07	I. Mood D/O NOS R/O Bipolar NOS PTSD R/O Conduct D/O II. Mild MR	This is not a behavioral plan of any kind.
099146	4-12-07	I. Schizoaff II. None	This is not a behavioral plan of any kind.

		Behavioral Treatment at DDH is well below standard as follows: **a) In order to provide the last five behavioral treatment plans, DDH had to go back over three months. This shows an inadequate use of behavioral treatment.** **b) Plans use Level System as some form of reinforcement. This is an improper use of levels which are designed to manage patients' current risk.** **c) Plans are predominately aversive, even punitive.** **d) Plans lack positive behavioral supports.** **e) Plans use contingency reinforcers at a frequency not at all addressing the needs and capacities of the patients.** **f) Plans show no evidence of how staff are to be trained.**	
Identified least restrictive interventions (IVC) **Explanation of psychopharmacological interventions with particular attention to the prescription of**	**PC**	**IDT's fail to refer patients to the PSR mall until "they are ready." This is not a meaningful construct.** **On Wednesday afternoon, September 26, 2007, 93 patients were on their wards and not at the Treatment Malls. Leaving out the forensic patients at DDH for competency evaluation, there were 77 patients. Excluding the patients on the medical service still left 71 patients or 22% of the census.**	**Consult Steve Webster.**

Benzodiazepines (IIID6) **Antipsychotic medications (IIID6)**	**NC**	**The majority of CTP's are silent concerning all psychotropic medication. A few include these. Use of PRN psychotropic medication as part of treatment is almost never discussed. When present, the description of intent and monitoring ranges from specific to generic. Overall, simply not there.**	
Criteria for use of seclusion and/or restraint as last resort (IVC)	*C*	*Clear in other places. Not specified in TP, but no requirement it be so.*	
Criteria for release from seclusion and/or restraint (IVF)	*C*	*Same as above.*	
Education about diagnoses (IIIC2)	**PC**	**10/14 patients' records revealed there was no informed consent executed for psychotropic medication.**	**Information often provided, but not in ways patients' could comprehend.**
Skill building for			
Problem-solving techniques (IIIC1)	**NC**	**This is the weakest part of the Treatment Plans. Skill building is either not there at all, or not there in any effective way. Only a very small minority of Treatment Plans have PSR groups as specific interventions for specific skill building. "The Mall" or comparable statements are not interventions. Almost to 100%, individual groups with group leader and frequency and duration of group is absent. Individual interventions aimed at skill building are almost invariably inadequate in frequency and duration. None of these skills can be developed with infrequent 10 minute interventions. There is virtually no use of HCT's to conduct practice sessions. No evidence of carryover from PSR Mall taught skills to using those skills on the ward.**	
Self-medication skills (IIIC3)	**NC**		
Symptom management (IIIC4)	**NC**		
Cognitive and psycho-social skills (IIIC5)	**NC**		
Moderation or cessation of substance use (if appropriate) (IIIC6)	**NC**		
Medical treatments (routine, preventative, emergency) (VB)	*C*	*Well done. Well documented.*	

Transition/Discharge planning that reflects the need for aftercare services (IIIB5c, VIIB1)	PC	**Ignores recidivism most of the time.** **Plans vary in quality from specific and meaningful to generic statements of no meaning at all, e.g., "supervised setting", "suitable setting", "facility setting able to meet his needs."** **Patient Transition to Central Regional Hospital (Hospital to Open March 1, 2008)** **Only those patients who are not yet ready for discharge or cannot be discharged because of legal reasons will be relocated to Butner. Admissions will be stopped at DDH at least one week prior to the move in order to decrease the number of acute patients needing to be relocated. Over the next 6 months the following will occur:** • **Orientation to the new hospital will become a group(s) in the mall for those patients being relocated or others who request this group. Once building is more complete, staff will video areas of the new hospital and use this video in teaching.** • **The CEO and Chief Operating Officer will meet with the Patient Quality Council to address concerns and questions.** • **A small group of patients will be taken on a tour of the new facility prior to opening so that they can ring information back to others.** • **A letter will go out to all guardians and families (as appropriate) of those patients being relocated to CRH. These letters will go out after the first of the year. As telephone numbers and room numbers become more finalized, additional information will have to go to families.** • **Starting in early January there will be a display board in the main lobby of DDH where visitors**	

		enter. The Executive Team at DDH will rotate being in the lobby during high visitor time to answer questions as needed. • **The CEO meets monthly with the LME directors from the south central catchment area which DDH serves. This group will receive all information sent to families and to the public. This group will be invited to tour the new facility once construction is further along.** **Recidivism and rapid readmission were examined in two ways: review of CTP's pulled for other reasons and review of problems from CTP's for patients with 10 or more admissions.** **On CTP's recidivism or rapid return was not identified as a problem, even for cases as follows:** **1081799 discharged 7-23-07, admitted 8-8-07** **1014092 two admissions in each of 05, 06, 07** **1079898 four admissions in 07** **discharged 8-7-07, admitted 8-9-07** **0959738 14th DDH admission** **1077908 5th admission in 07** **0991263 first DDH, but 13-year-old with multiple** **psychiatric hospitalizations since age 4 years old** **Occasionally recidivism was found as a problem:** **30872212 (act) "recidivism (sic) related to noncompliance with meds"** **0390785 with 1.5 weeks discharge to readmission: "Ambivalence about discharge which impedes necessary discharge planning"** **The problem lists showed:** **Med# # of admits Problem list** **0384141 26 Recidivism not a problem** **0990438 21 Recidivism not a problem** **0393873 17 "Rapid readmissions due to med noncompliance affecting placement**	

		options” **0374626 15 “Rapid readmission resulting from noncompliance”** **0995805 12 Recidivism not a problem** **06100475 10 Recidivism not a problem** **1004892 10 Recidivism not a problem** **1003050** **DDH admits in last 2 years:** **07 – 3 admissions** **06 – 6 admissions** **Last admission – no discussion of frequent admits to DDH.** **Dx: I. Alcohol Dependence** **Depression NOS** **II. Borderline PO by hx** **0997896** **Should be fast tracked for discharge. Returned to DDH because he was lonely in small group home. He is “happy to be back” and considers DDH to be his “home.”** **See SW note 9-26-07** **Was never suicidal. (Should have gone to crisis bed.)** **Why change antipsychotic medication?**	

Policies

Item	Compliance	Findings	Comments and Recommendations
Ensure patients with “special needs” are appropriately evaluated, treated and monitored Suicide risk (IIIB4)	*C*	*See P14, P15.*	
Self-injurious behaviors	*C*	*See P14, P 15.*	
MI/MR, MI/SA (IIIB2)	**PC**	**MI/MR: Not by policy, but by protocol and**	

Hearing impaired (IIIB6)	C	**practice.** **MI/SA: No policy. Practice is inadequate.** Deaf population moved to BH. Evaluations of hearing impaired as per standard medical practice.	
Reduce the use of forced intramuscular medication that differs from the patient's prescribed oral medication (IIID4b)	*C*	*Per P5: NEFM (non emergency forced medication) orders for standing medications are valid for 7 days. EFM (emergency forced medication) orders are limited to 3 days.*	
Use of restraints or seclusion (IVA,D)	*C*	*See P1.* *Per P1: Mechanical restraints and seclusion shall not be used together except in extreme circumstances and only with the consent of the Hospital Clinical Director.* *Per P1: If the patient cannot be released within 12 hours or has two or more separate episodes of a restrictive intervention in a 12-hour period, and for each succeeding 12 hours, the following procedure shall be implemented: a) the registered nurse shall notify the patient's attending physician; b) the attending physician shall notify the appropriate Service Chief during business hours or Administrative Physician On-Call after business hours to request review and approval; c) during business hours, the assigned Service Chief or designee will review and approve any further use of restrictive interventions; d) after business hours the registered nurse shall notify the psychiatric physician on call who in turn shall notify the administrative physician on call for review and approval. The psychiatric physician on call, or the administrative physician on call if he/she is in the hospital, shall review and approve any further use of restrictive interventions and document the findings of this review in the patient's record.*	Under what circumstances would this be the case? This should be an absolute prohibition; when a patient is in restraints he/she cannot simultaneously be in seclusion.

		Per P1: Following each use of a restrictive intervention, the treatment team shall review the incident prior to the end of the next business day. The treatment team shall develop a restrictive intervention prevention plan within 10 business days when a restrictive intervention is used on 3 occasions, for 40 cumulative hours, or for 24 continuous hours in a calendar month.	
Use of PRN psychotropic medications (IVB)	*C*	*Per P5: All PRN orders for antipsychotics and for benzodiazepines are limited to 4 days. The use of PRN antipsychotic medications on long term units, other than FMAX, will require the approval of the Service Chief. The use of atypical antipsychotic medications PRN on any unit requires the approval of the Service Chief or Service Medical Director. The use of Risperidone on GERO for sundowners does not require any approval.* *Per P6: All physician orders for medications at higher than recommended dose ranges must contain a reference to a progress note at the end of the order, i.e., progress note.*	*Consider no PRN psychotic medication. Consider no PRN psychotropic medication except on acute units.*
Individual with health problems are identified, assessed, diagnosed, treated and monitored	*C*	*Consistently well done.* *Sometimes confusing when psychiatrist and when medical MD is following a medical problem.*	

Procedures

Item	Compliance	Findings	Comments and Recommendations
Health problems (identified, assessed, diagnosed, treated and monitored) (VB)	*C*	*Medical care and treatment for patients admitted to DDH is directed, in part, by SCPM No. P-5a; Patient Management Standards for Medical Services; SCPM NO. M-6; Medical/Psychological Staff consultations; Nursing Policy No. II-8-8; Code Blue: Emergency Resuscitation. Patients received in screening and Admissions are assessed for admission. There are Nursing protocols for*	

		consulting medical physicians while the patient is still in Screening and Admissions. This is triggered by abnormal vital signs and also by other conditions as determined by the Intake Physician. If it is determined the patient is to be admitted and has a medical condition needing immediate evaluation and/or treatment, the patient is transferred to Medical Services. The Medical Physician completes a physical examination and orders treatment. If a patient has a condition that cannot be managed at DDH, the patient will be transferred to an outside facility to receive treatment. Patients admitted to DDH with non-acute medical needs are managed on the psychiatric units. All patients who are admitted to the psychiatric unit are reviewed by the assigned medical provider and medical issues are managed by the medical provider. Communication between Nursing and Medicine is facilitated by placing information on the Physician Extender's clipboard for review and evaluation in addition to verbal and other written communications. Acute medical needs after admission will first be evaluated by the unit's assigned medical provider who will determine the care that is needed. The Medical Unit provides consultation/treatment for patients with medical care needs outside the scope of psychiatric unit nurses' competencies (i.e., porta cath access, complicated wound care, etc). *Admission H&PE routinely done.* *Medical Treatment Plan routinely done.*	
Investigating untoward events, serious injuries, and sentinel events (V1A2)	*C*	*A root cause analysis is a peer review process by which causal factor contributing to a sentinel event (reviewable or non-reviewable) are identified. This analysis focuses primarily on systems and processes, not individual performance; repeatedly questions "why" until no other logical answer can be identified; and identifies changes that can be made to improve the*	

		level of performance and reduce the risk of recurrence. During business hours the Risk Manager will notify the Hospital Director and the Clinical Director when an occurrence may be considered a Sentinel Event based on preliminary facts and circumstances of the event. During off hours the administrative psychiatrist or medical director will notify the clinical director. The Clinical Director as and applicable Service Chief authorized by the Quality Council, shall appoint individuals to serve on the Sentinel Event team. This team shall convene no more than 3 business days from being notified of the event. The root cause analysis shall include determination of the primary cause of the sentinel event and the process(es) and system(s) related to its occurrence, and an analysis thereof. *See also Documentation Section at "Actively collecting…"* *Two examples of incident investigation→recommendations for change→implementation of changes reviewed in their entirety.*	
Routinely reviewing incident reports to assess individual or systemic trends or issues exist and changes in treatment are warranted (V1A3) Investigating untoward events, serious injuries, and sentinel events (VIA2) Routinely reviewing incident reports to assess whether	*C* *C*	*"Incident reports" for all December 2006 reviewed.* *Quality indicators tracked and reviewed include actual assaults, use of 4-point restraints, use of seclusion, preventable deaths, escapes, among others.* *PI indicators include assaults and 4-point restraint usage (forensics), problems with resuscitation (medicine).* *"Incident Reports" for December 2006 reviewed Quality indicators include accurate and timely assessment of falls, needle sticks among*	

individual or systemic trends or issues exist and changes in treatment are warranted (VIA3)		*employees, medication errors, medication variance, mislabeled lab specimens.* *PI indicators include medication errors (nursing), crash cart stocked and operational (pharmacy), respiratory therapy equipment operational and labeled with patient's name (respiratory therapy).*	

Practices

Item	Compliance	Findings	Comments and Recommendations
Case formulation (IIID6)	**PC**	**28353 on Psychiatric History and Admission Note – well done.** **On the other hand, there are assessments with no formulation – 28204.** **Also Annual Psychiatric Assessment without formulation – 1044266.**	**Either train psychiatrists or train all members of IDT in writing formulations.**
Monitored, documented, and reviewed by qualified staff (IIID1) **Use of anti-psychotics** **Medication combinations**	**SC**	**Polypharmacy. Examination of the use of two or more antipsychotic medications showed 243 patients on antipsychotic medication on 9-14-07. None were on more than two antipsychotics. Those patients on two antipsychotics were:** **2 atypicals 16** **1 atypical + 1 typical 22** **1 antipsychotic + 1 PRN 6** **2 typicals 2** **Total 46** **Percent of 2 antipsychotics 19%** **<u>Psychotropic Medication Documentation</u>** **I reviewed five long-term patients' psychiatry progress notes**	

1-1-07 through 8-31-07. Per this review:

Med #	# of Notes	Rationales	Polypharm
0374357	33	Present and changes explained	Explicit notes
1003136	18	Present and changes clear	N/A
1076905	22	Present and clear	N/A
0966000	42	Present and documentation well done	Explicit notes
1077062	53	Present and tracks all medication changes	Explicit notes

I reviewed five forensic patients' psychiatry progress notes 1-1-07 through 8-31-07. Per this review:

Med #	# of Notes	Rationales	Polypharm
1044078	23	Best stated in monthly Physician Summary, but there were only 3 for 8 month period. Rationale stated in a few of the progress notes.	N/A
0396604	19	Ten monthly summary notes, but 4 written in July to cover	N/A (not on any psychotropic meds)

		earlier months not done during the month.	
0155088	**25**	**7/8 monthly summary notes. 3/18 progress notes address meds.**	**N/A**
1005818 (6-7-07 to 8-31-07)	**7**	**2/2 monthly summary notes. No rationale for meds provided, e.g., why P.O. and I.M. haloperidol?**	**N/A**
1042043		**3/9 monthly summary notes one late entry done in August. 5 psychiatry progress notes in 8 months – none discuss med. Therefore, patient visits for several months with no psychiatrist notation about meds (and patient is on 2 antipsychotics).**	**Cursory notations.**

The Physician Summary, due monthly is a good form. Writing several months worth of monthly summaries for periods months earlier all on one day is treating the chart only.

I reviewed five gero patients' psychiatry progress notes 1-1-07 through 8-31-07. Per this review:

Med #	# of Notes	Rationales	Polypharm
0336389	**24**	**Most notes**	**N/A**

DDH might add a specific section titled "Rationale for Medications" directly above the "Response to Medication." DDH needs to monitor physician compliance with the monthly documentation, which must be done monthly.

		mention meds, but statement is exactly the same for 8 months. No evidence of effort to titrate down on dose or explain why not.		
1030270	**24**	**Most notes mention meds, but statement is exactly the same for 8 months. No evidence of effort to titrate down on dose or explain why not.**	**N/A**	
1074977	**38**	**Better documentation with active treatment and medication changes.**	**N/A**	
1081143 (6-13 to 8-31-07)	**15**	**Weekly psychiatrist note generally informs about medications.**	**N/A**	
1069301 (6-7 to 8-31-07)	**17**	**Notes silent on medication until case transferred 8-7-07**	**N/A**	

Documentation practices on Gero Unit need to be improved. There are too often no notes about psychotropic medications or a duplicate statement month after month.

Pro re nata (PRN) orders (IIID2)

SC

PRN's

Policy covering prn psychotropic medication is well conceived:

All PRN orders for anti-psychotics and for benzodiazepines are limited to four days. The use of PRN antipsychotic medications on long-term units, other than FMAX, will require the approval of the Service Chief. The use of atypical antipsychotic medications PRN on any unit requires the approval of the Service Chief or Service Medical Director. The use of Risperidone on GERO for sundowners does not require any approval.

PRN antipsychotic medication orders on 9-14-07 were:

Chlorpromazine	**1**
Haloperidol	**9**
Total	**10**
Percent	**4%**

PRN benzodiazepine orders on 9-14-07 were:

Orders	**43 patients**
Percentage	**18%**

Progress notes for patients on prn psychotropic must record number of doses and how that affects standing orders on a regular frequency.

Intramuscular injections (IIID5)

PC

An examination of the 5 most recent patients receiving IM antipsychotics showed:

MRUN	Ward	Date	Drug	Note at Order	Note by Attending
1084149	AAC	9-26-07	Haldol* 10mg	No	No
1052390	GERO	9-25-07	Haldol* 5mg	No	No
0922786	ALM	9-25-07	Haldol** 5mg	Yes	No
1052276	AAF	9-22-07	Haldol* 5mg	No	No
1049322	AAF	9-22-07	Geodon** 20mg	Yes	No

***also lorazepam IM**
****IM for PO refusal**

Benzodiazepines (IIID2)		**These data indicate that when IM medication is ordered as a STAT or now order, there is no note by the ordering physician. The Attending also fails to address the IM administration in her/his next progress note. When IM is ordered by the Attending Psychiatrist as a substitute for a PO refusal, there is a note upon the order, but no follow-up note about the actual administration.** **Benzodiazepine** **Benzodiazepine orders for patients – including standing orders and prn's – were, on 9-14-07:** **Patients 69** **Percentage 28%** **With the exception of two patients, all patients had orders for lorazepam with dosages ranging from 0.5mg to 12mg/day (the latter if all PRN doses possible were administered, i.e., 2mg PRN every 4 hours).**	

Protocols

Item	Compliance	Findings	Comments and Recommendations
Nursing protocols for medical care and treatment (VC)	*C*	*See Procedures Section, "Health problems…"*	
Nursing protocols to ensure that patients are appropriately supervised and monitored (VIB2)	*C*	*See P14, P15*	

Plans

Item	Compliance	Findings	Comments and Recommendations
Appropriate evacuation plans (VIB3)	*C*	*Detailed plans reviewed.*	

Physical Plant

Item	Compliance	Findings	Comments Recommendations
Modifications for hearing impaired (IIIB6)	*C*	*Deaf patients no longer treated at DDH; unit moved to BH.* *Visual fire alarms (strobes) in treatment mall.* *Staff removes all patients from wards in case of fire or disaster per DDH evacuation plan.*	
Eliminate to a reasonable degree all suicide hazards in patient bedrooms and bathrooms (VIB1)	**C**	**Physical Plant** **JCAHO survey (8-07) noted hanging risks in the Research building.**	**Policy modification made subsequent to visit as a consequence of visit. New policy substantially decreases risk through environmental checks.**

Staff Training

Item	Compliance	Findings	Comments and Recommendations
Writing behavioral goals and objectives (IIIA3)	**PC**	**See CTP's annotated and those reviewed.**	**Based on review of Treatment Plans, further training is needed.**
Serving the needs of patients requiring specialized care (suicide risk (IIIB4)), SIB, MI/MR, MI/SA (IIIB2), Hearing impaired (IIIB6)	**SC**	**See pages 10-13.**	**MI/SA needs work.**
Risks and side effects in administering benzodiazepines	*C*		
Risks and side effects in administering antipsychotic medication	*C*		

Specific Documentation Requirements

Item	Compliance	Findings	Comments and Recommendations
Behavioral goals and objectives which include, when possible,	**PC**	**See annotated CTP's.**	**Remains one of the weaker aspects of the CTP.**

patient and family input (IIIA3)			
Treatment plans shall reflect an interdisciplinary process based upon reliable objective data and clearly established measurable goals (IIIA5a)	**PC**	**See annotated CTP's.**	**Improvement, but still needs considerable work.**
Use of all medications (IIID1)	**PC**	**See Medication section.**	**Need to focus on rationales, especially on admission.**
Identify the symptoms and/or behavioral problem and tie to justification for the use of any antipsychotic medication or benzodiazepines (IIID4)	**PC** **SC**	**Statements often too generic.** **Multiple medications in same class without evidence.** **See pages 31-34.**	
Clearly document behavioral issue(s) and tie to justification for use of intramuscular medication (IIID5a)	**PC**	**STAT medications rarely documented**	**Each use of STAT IM administration needs to be followed up with a progress note by the Attending Psychiatrist.**
Use of restraints and seclusion documented and reviewed in a timely fashion by qualified staff (IVE)	*C*	*Behavioral Interventions Committee (BIC) is a Medical/Psychological Staff Committee that meets on a regular basis to review use of restrictive interventions in the hospital. The BIC makes recommendations to the Medical/Psychological Executive Committee and the Quality Council for reducing use of restrictive interventions, improving their safety, increasing the use of alternative interventions and insuring compliance with state regulations and accrediting agency requirements. The BIC reviews and approves restrictive intervention prevention plans and provides feedback to the attending physician and to the appropriate Service Chief.* *Accomplished, in part, through Occurrence Reports.*	*Several documented examples of injuries occurring in December to patients in seclusion or restraint. If these are not isolated examples, DDH needs to review these cases for systemic corrective action.*
Criteria for release from restraints and seclusion clearly identified and	*C*	*Discharge follows aftercare planning which is a collaborative process involving the patient, family,*	*Found in records in other than CCTP which is fine.*

written in patient's treatment plan (IVC)		*referring Local Mental Health Entity (LME), receiving Local Mental Health Entity (LME) if applicable and potential provider(s). A written aftercare plan shall be developed prior to the patient's discharge or trial placement from the hospital. The physician shall complete a discharge summary within 48 hours after discharge or release on a trial placement.*	
Provisions of nursing and medical care (VD)	*C*	*Well documented on admission – see above.* *Documented through Medical Treatment Plan – see above.* *Progress notes thorough and explanatory, traces evolution of treatment.*	

Quality Assurance and Performance Improvement

Item	Compliance	Findings	Comments and Recommendations
Detect timely and adequately problems with the provision of protections, treatment, services and supports and to ensure that appropriate corrective actions are implemented (VIA1)	*C*	*Review of all Occurrence Reports for December 2006 indicates this is occurring. Multiple examples of appropriate corrective actions found.*	
Actively collecting data relating to the quality of nursing and medical services (VIA1a) Assessing data for trends (VIA1d) Initiating inquiring regarding problematic trends and possible deficiencies (VIA1c)	*C*	*See also Procedures section at "Investigating…"* *An Occurrence/Error is any unexpected or unintended event or act that has potential for or has had a negative impact on the individual's physical or emotional well-being and/or has risk management implications for the hospital (i.e. liability concerns, legal implications, etc.). An Adverse Event is an untoward, undesirable, and usually unanticipated event such as death or serious injury. Reported errors and occurrences will be reviewed for serious adverse outcomes requiring immediate action, scored according to*	

Identifying corrective action (VIA1d) Monitoring to ensure appropriate remedies achieved (VIA1e)		*the Occurrence Report Scoring Grid, recorded, trended, and analyzed for use in determining priorities for risk reduction and performance improvement activities. All staff have the responsibility to report occurrences they witness. Failure to report known errors or occurrences as outlined in this policy may result in disciplinary action. Any error or occurrence that receives a risk score of 4 or higher may be deemed an adverse event. Risk Management shall initiate an intensive analysis utilizing staff as necessary.* *Data from occurrence reports are collected, aggregated, and analyzed utilizing available data management systems. Monthly summary reports are provided to appropriate individuals as well as the Risk Management/Patient Safety Committee.*	
Conducting adequate mortality reviews to ascertain the root causes for all unexpected deaths (VIA4)	*C*	*Death reviews shall be carried out within one month of a patient's death or as soon as pertinent data are available, not to exceed three months. The review shall include assessment of the completeness of the medical record, content of the clinical notes, and appropriateness of clinical management. The Chief of Medical Services shall insure that death reviews are conducted and documented according to procedures described herein, and that follow-up investigative and/or corrective actions are taken when needed.* Eleven deaths reviewed July 1, 2006-September 14, 2007.	
System to oversee discharge process (VIIB3)			

Communication

<table>
<tr><th>Item</th><th>Compliance</th><th>Findings</th><th>Comments and Recommendations</th></tr>
<tr><td>Physician orders for enhanced supervision be communicated to appropriate staff (IIIB4b)</td><td>C</td><td>Special observation for Suicidality

1084117 9-25-07 Suicide Precaution (9-25 to 9-27-07)
1084129 9-25-07 Constant (9-25 to 9-25-07)
15 minute (9-24 to current)</td><td>No evidence for negative trends on this parameter.</td></tr>
<tr><td>Treatment team members communicate and collaborate effectively (IIID7)</td><td>PC</td><td>Restraint and Seclusion Episodes and Hours 1/2000 – 7/2007
<table>
<tr><th></th><th colspan="2">Restraint</th><th colspan="2">Seclusion</th></tr>
<tr><th></th><th>Episode</th><th>Hours</th><th>Episode</th><th>Hours</th></tr>
<tr><td>2000</td><td>960</td><td>1726</td><td>922</td><td>948</td></tr>
<tr><td>2001</td><td>697</td><td>1520</td><td>424</td><td>572</td></tr>
<tr><td>2002</td><td>611</td><td>3034</td><td>396</td><td>506</td></tr>
<tr><td>2003</td><td>694</td><td>1408</td><td>275</td><td>481</td></tr>
<tr><td>2004</td><td>740</td><td>722</td><td>381</td><td>284</td></tr>
<tr><td>2005</td><td>603</td><td>842</td><td>548</td><td>743</td></tr>
<tr><td>2006</td><td>798</td><td>1458</td><td>698</td><td>1168</td></tr>
<tr><td>2007 (7 months)</td><td>[377]</td><td>373</td><td>411</td><td>644</td></tr>
<tr><td>2007 annualized</td><td>646</td><td>640</td><td>705</td><td>1104</td></tr>
</table>
Assaults and Serious Injuries, 2000-2007
<table>
<tr><th>Year</th><th>Staff Assaults</th><th>Patient Assaults</th><th>Patient Injuries (serious)</th></tr>
<tr><td>2000</td><td>266</td><td>340</td><td>18</td></tr>
<tr><td>2001</td><td>229</td><td>280</td><td>15</td></tr>
<tr><td>2002</td><td>37</td><td>98</td><td>1</td></tr>
<tr><td>2003</td><td>144</td><td>235</td><td>1</td></tr>
<tr><td>2004</td><td>154</td><td>503</td><td>1</td></tr>
<tr><td>2005</td><td>99</td><td>465</td><td>9</td></tr>
</table></td><td>Some troubling trends:
Increasing use of seclusion
Increasing staff assaults
Positive trends
Decreased LOS of restraint
Decreasing patient-on-patient assaults</td></tr>
</table>

		2006 133 343 3 **2007 211 120 0** **(7 months)** **Serious Incidents** **1077167: Treatment Plan not followed by HCT; HCT did not have access to information on a cared to be carried by HCT.** **RN not notified by HCT's of their intended actions.** **See material on CTP's and on Communication.**	
Adequate and appropriate interdisciplinary communication among relevant professionals (VE,VI)	**PC**	**Days on Admission Delay Status (Census at 110%) 2007** **Month — Number of Days** **March 3** **April 2** **May 25** **June 14** **July 10** **August 22** **September 12** **(half the month)**	**To what degree does staff function affect census management?**

Staffing Requirements

Item	Compliance	Findings	Comments and Recommendations
Ensure a sufficient number of qualified staff to supervise suicidal patients (IIIB4b)	**PC**	**Staffing** **RN: August 2007** **DDH personnel 1961 hours** **Agency/Travel pool 759 hours** **Percent Agency/Travel 28%** **Psychiatrists: August 2007** **Filled 21.375 FTE** **Vacant 2.75 FTE**	**Staff not adequate when AAU over census.**

<table>
<tr>
<td></td>
<td></td>
<td>Percent vacant 11%

IDT's not clear if dialectical behavioral therapy (DBT) occurs at this time at DDH; is provided on the acute unit Mall, but is not available to LT patients; or could be accessed for patients on LT units. See for example, 0390785.

Serious Incident
1003050: Inadequate supervision of patients → 4 self-injurious episodes of ingestion of toxic liquids between 1-17-07 and 3-5-07.</td>
<td></td>
</tr>
<tr>
<td>Hire and deploy sufficient number of qualified direct care and professional staff, particularly psychiatrists and nurses, necessary to provide patients with adequate supervision and medical and mental health treatment (VA)</td>
<td>C</td>
<td>DDH Staffing Ratios (functional)
<table>
<tr><th></th><th>Psychiat</th><th>Psychol</th><th>SW</th></tr>
<tr><td>Unit</td><td></td><td></td><td></td></tr>
<tr><td>Admit</td><td>1:10</td><td>1:31</td><td>1:6</td></tr>
<tr><td>LT</td><td>1:26</td><td>1:32</td><td>1:10</td></tr>
<tr><td>Gero</td><td>1:12</td><td>1:24</td><td>1:8</td></tr>
<tr><td>Child</td><td>1:11-1:14</td><td>1:12</td><td>1:5</td></tr>
<tr><td>Med</td><td>—</td><td>—</td><td>1:24</td></tr>
<tr><td>CRU</td><td>1:5</td><td>—</td><td>1:16</td></tr>
<tr><td>Forensic Rx</td><td>1:29</td><td>1:980</td><td>1:14</td></tr>
<tr><td>Pretrial</td><td>1:6-1:12</td><td>1:8</td><td>—</td></tr>
</table>

There are 7 Rehab staff devoted to the child unit (1:8) and there are 45 rehab staff in the centralized mall program, producing a ratio of 1:8 for adult patients.

Nursing coverage examined as Nursing Hours Per Patient Day (NHPPD) shows by ward the average number of times below 5.5 for the two-week period of December 1-14, 2006 to be:
<table>
<tr><th></th><th><u>Average</u></th><th><u>No. times below 5.5</u></th></tr>
<tr><td>AAF</td><td>10.09</td><td>0</td></tr>
<tr><td>AAM</td><td>10.06</td><td>0</td></tr>
<tr><td>AAC</td><td>8 of 3</td><td>0</td></tr>
</table>
</td>
<td></td>
</tr>
</table>

		ALF 6.28 0 *ALM 6.89 1* *Geo 10.84 0* *Med 23.54 0* *CHA 8.56 0* *CHL 8.31 0* *PTA 11.41 0* *FMAX 6.89 0* *FMIN 4.04 14* *FMED 6.27 1* *FMIN is never at even 5.0, but this is a minimum security forensic unit. Further, patients are off at rehabilitation during most of the day shift. The two other instances occur on wards where the usual applicable standard would be 5.0 and each instance exceeds this number.* *Examining RN coverage for the two-week period December 1-14, 2006, there was no instance on any of the three shifts where there was not at least one (1) RN working on each ward.*	

If you should have any questions about this report, please feel free to contact me by telephone at 508-856-6527, by fax at 508-856-3270, or via email at jeffrey.geller@umassmed.edu.

Respectfully submitted,

Jeffrey Geller, M.D., M.P.H.

JG:vab